STUDY PROJECT

COMMAND AND CONTROL OF THE ARMY DENTAL CARE SYSTEM

BY

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USAWC MILITARY STUDIES PROGRAM PAPER

COMMAND AND CONTROL OF THE ARMY DENTAL CARE SYSTEM

AN INDIVIDUAL STUDY PROJECT

by

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ABSTRACT

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GLOSSARY

Abbreviations

AADS	American Association of Dental Schools
ADA	American Dental Association
ADCS	Army Dental Care System
ADL	Area Dental Laboratory
AHS	Academy of Health Sciences
AMEDD	Army Medical Department
ARSTAF	Army Staff
ASG	Assistant Surgeon General
C2	Command and Control
CDC	Centers for Disease Control
CG	Commanding General
CONUS	Continental United States
DA	Department of the Army
DC	Dental Corps
DCG	Deputy Commanding General
DCSCS	Deputy Chief of Staff for Clinical Services
DCSDEN	Deputy Chief of Staff for Dental Services
DCSIM	Deputy Chief of Staff for Information Management
DCSLOG	Deputy Chief of Staff for Logistics
DCSOPS	Deputy Chief of Staff for Operations
DCSPER	Deputy Chief of Staff for Personnel
DCSRM	Deputy Chief of Staff for Resource Management
DCSVET	Deputy Chief of Staff for Veterinary Services

DDS	Directorate of Dental Services
DENTAC	Dental Activity
DOD	Department of Defense
DSG	Deputy Surgeon General
EPA	Environmental Protection Agency
FOA	Field Operating Agency
FORSCOM	Forces Command
GDEB	Graduate Dental Education Branch
HCDC	Health Care Delivery Command
HCP	Health Care Policy
HPR	Health Preparedness and Readiness
HSC	Health Services Command
MACOM	Major Command
MC	Medical Corps
MEDCEN	Medical Center
MEDDAC	Medical Department Activity
MEDSAC	Medical Support Activity
MSC	Major Subordinate Command
NCR	National Capital Region
OTSG	Office of the Surgeon General
PA&E	Program Analysis and Evaluation
RDA	Research Development and Acquisition
RDAC	Research Development and Acquisition Command
TQM	Total Quality Management
TSG	The Surgeon General

USAEHA	United States Army Environmental Hygiene Agency
USAHPSA	United States Army Health Professions Support Agency
USARJ	United States Army Japan

Introduction

On 3 March 1991 The Army Dental Corps will celebrate its 80th Anniversary. For most of its history the Corps has been firmly under the thumb of the physicians. At its best this relationship engendered benign neglect, but at its worst it resulted in malevolent manipulation with chilling effects on morale and retention.

The Defense Authorization act of 1979 emancipated the Dental Corps. It established Dental Activities (DENTACS) with Dental Officer Commanders as a matter of public law. Simultaneously the Chief of the Army Dental Corps was ensured access to the Army Staff. In essence the law created a new entity which is now called the Army Dental Care System (ADCS). The result was dramatic improvements in efficiency, morale, and retention.

Today, the ADCS may be in jeopardy. Proposed reorganization schemes for the Army Medical Department (AMEDD) could change the structure which has proven so effective for the delivery of dental care.

This paper will review the ongoing process for reorganization of the AMEDD. The history of the ADCS will be briefly sketched to develop an appreciation of the current organization. Then the existing structure will be outlined with emphasis on those features that must be retained to protect the efficiency of the system. One proposal for reorganization will be presented and modifications to that proposal will be suggested. These changes will preserve and continue the many outstanding achievements of

the ADCS while fostering further improvements.

Reorganization of the AMEDD

The impetus for reorganization of the AMEDD comes as part of the Army's overall effort to downsize in response to a perception of a reduced threat. Originally the relook at the command and control (C2) of the AMEDD was a part of the Quicksilver study but The Surgeon General (TSG) decoupled C2 from other proposed reductions so that this important issue could be addressed with greater focus. A Command and Control Task Force of senior staff officers under the direction of The Deputy Surgeon General (DSG) was established.

The task force has been meeting for the past year and continues to meet. The process is a moving train, one that is moving swiftly. Fortunately there has been considerable groundwork accomplished by a previous AMEDD Command and Control study. "On 15 February 1986, the Director of the Army Staff granted approval to conduct a study to determine the optimum command and control structure for the AMEDD in the United States."‹1› That study was completed on 16 June 1987. The recommendations of the study were never implemented because they were not politically feasible at that time.‹2› The Army was not ready to fight the powerful Texas congressional delegation which holds power in the home state of the Medical Major Command (MACOM), U.S. Army Health Services Command (HSC). The delegation had shown a marked predilection to vigorously oppose any action

which could result in a loss of jobs or services for constituents.

What was not feasible in 1987 is mandated today. The results of the 1986-87 study have been reviewed and the conclusions regarding the relationship between TSG, HSC, and The Army Staff (ARSTAF) are still appropriate:‹3›

(1) TSG's authority not commensurate with responsibility.

(2) Unclear lines of authority.

(3) Duplication of functions.

(4) Broad span of control.

(5) Inadequate strategic planning.

(6) Inadequate programming for resources.

(7) Malalignment of Academy of Health Sciences (AHS), and U.S. Army Environmental Hygiene Agency (USAEHA) under HSC.

The recommendations arising from the study included the disestablishment of HSC and the creation of a new Medical MACOM under the command of TSG collocated with the Office of TSG (OTSG) in the National Capitol Region (NCR).‹4› Implementation of these recommendations will help alleviate the problems listed in the study's conclusions seen above. The senior leadership of the Dental Corps supports the recommendations, but is concerned that in the process of creating a new structure for the AMEDD some of the positive aspects of the current system will be lost with resulting detriment to the ADCS and its beneficiaries.

The Dental Corps is almost obsessive about its prerogatives. To understand the Corps' concerns one must develop an appreciation of the history of the ADCS.

History of the Army Dental Care System

The Army Dental Corps was established on March 3, 1911 when existing contract dental surgeons were afforded probationary commissions with the rank of First Lieutenant. These individuals had been serving with the Army since 1901 when they were hired to provide dental care to the troops in the far flung territories acquired in the Spanish American War.‹5› Their mission was then, as it is now, to conserve the fighting strength. The National Defense Act of 1916 removed the requirement for the probationary period thereby elevating the status of the Corps. However, it was not until 1938 that the Corps was granted flag rank for its Chief, the Director of the Dental Division, Brigadier General Leigh Fairbank.‹6› Expansion of the Corps to 15,000 officers during World War II provided the impetus for a two-star billet for the Chief. On March 17, 1946 the permanent rank of Major General was authorized. The first 35 years had brought hard won improvements to the Dental Corps. The position of its Chief was established in law but this status was questionable as TSG represented the Dental Corps to higher authorities.‹7›

The status of Dental Corps (DC) officers at installation level was even more dubious:

"Officially, the dental surgeon was an advisor to the surgeon, without formal authority even within the clinic. Here again,the actual status of the dental surgeon depended upon the attitude of the surgeon. Many medical officers routinely consulted the dentist on matters concerning the dental service and accepted his advice in the absence of important reasons to the contrary. On the other hand, it cannot be denied that a

determined surgeon could, by invoking his authority to make out efficiency reports, completely dominate the dental service, even in respect to determining treatment or assigning personnel within the clinic, matters which were specifically reserved to the dental officer by regulation. The dentist was not inclined to demand even his legal rights if he could expect, as a result, to receive a poor efficiency rating and be transferred to an undesirable post because he was "uncooperative".'8'

The National Defense Act Of 1947 provided some relief from the perverse relationships outlined above. It allowed DC officers to command dental units under the overall command of the installation commander.'4' As the post dental surgeon, the senior DC officer had equal staff responsibility to the post medical surgeon. However, TSG still represented the Dental Corps to the Department of the Army (DA), the new Department of Defense (DOD), and Congress.'9'

The next two decades were a period of relative enlightenment for the Dental Corps. Emphasis was placed on dental and military education. Post graduate dental education programs were established and the first dentist graduated from the Army War College in 1960. The Army Preventive Dentistry Program was inaugurated in 1960. The United States Army Institute of Dental Research was activated in 1962 and the first high speed dental operating unit was introduced to the field environment in 1965. A most significant achievement was the designation of the Chief as **both** Chief of the Army Dental Corps and Assistant Surgeon General for Dental Services.'10' Unfortunately, the impetus for progress reversed dramatically in 1967 and the Corps entered what the most recent past Chief calls the "dark ages" of the Army Dental Corps.'11'

What happened? In 1967, Army Regulation 40-4 established the Medical Support Activity (MEDSAC) with all installation health care assets under a single Medical Corps (MC) commander. A year later the MEDSAC evolved into the MEDDAC (Medical Department Activity). The new relationship denied dentists access to the installation commander.‹12› The results were devastating in terms of morale and efficiency. By 1974 the Corps had the lowest retention rate of young officers in the entire Army. Productivity had fallen 17% by 1975. There were some very peculiar aspects of the MC's stewardship that exacerbated the Dental Corps' problems. Fenced dental funds and personnel were diverted and at least one dental facility was misappropriated. MC officers were receiving four times as many funded continuing education experiences as DC officers. The dental facilities construction program was ignored and in 1975 63% of dental clinics were still housed in temporary structures.‹13› It is little wonder that dentists had lost faith in the leadership of their MC colleagues and departed the service in droves.

By 1975 the situation had become so critical that TSG directed a review of the organization for dental services. This initiated a series of actions that culminated in the Dental Corps Reform Bill as a part of the 1979 Defense Authorization Act. The bill changed Title 10, United States Code, section 3081. The most salient aspects of the modification mandated that "all matters relating to dentistry shall be referred to the Chief of the Army Dental Corps" and "dental and dental auxiliary personnel

throughout the Army shall be organized into units commanded by a designated Dental Corps Officer."(14) With the bill's signing on 20 October 1978 the ADCS was born--a system composed of officers, enlisted members, and DA civilians. It should be noted that the AMEDD fought these changes because they were viewed as divisive. It was through the spirited efforts of the Corp's Chief, MG Surindar. N. Bhaskar, with the help of the American Dental Association, and key line officers on the ARSTAF that this determined opposition was overcome.(15)

The results of the reform were dramatic. Productivity increased 153% from 1975 to 1989, and there was a six-fold increase in retention of junior officers.(16) The record of accomplishments in the past 12 years is unprecedented. LTG (Ret) Richard G. Trefry, former Inspector General of the Army, wrote that "... the contributions of the Army Dental Corps has far exceeded its modest size and lack of formal recognition."(17) Today the Corps takes great pride in its many achievements:(18)

1. Leadership in dental research, forensic dentistry,and dental implants.

2. Proponency for the Family Member Dental Insurance Plan.

3. Wartime roles training--800 DC officers have completed the Combat Casualty Care Course and 675 DC officers have earned the Expert Field Medical Badge.

4. All DC Officers have state dental licenses.

5. Implementation of the Dental Leadership Program.

6. First in the AMEDD to implement Total Quality Management

(TQM).

MG Bill B. Lefler, the immediate past Chief, has called the past 12 years the "golden age" of Army Dentistry.‹19› Indeed, compared to the preceding period, things do appear golden for the ADCS. LTG Trefry stated that "Dentists are no longer adjuncts or orphans in either the military or the medical community. While some might question the perception that they were, there was no question that the dentists believed it."‹20›

It is because the Corps has come so far since its "dark ages" that it is concerned that any reorganization could once again shut out the light. History taught the dentists that what is best for the physicians is not always best for the dentists. Furthermore, the Corps has seen how quickly improvements can be wiped out with organizational change. The 1967 changes to Army Regulation 40-4 which ushered in the Corps' "dark ages" seemed benign enough at the time. It is prudent in light of this historical perspective to reorganize cautiously with an eye to retaining those aspects of the current structure which have fostered the "golden age" of Army dentistry.

Current Organization of the Army Dental Care System

Dentists and their auxiliary personnel are now organized into three types of units for the provision of dental services:

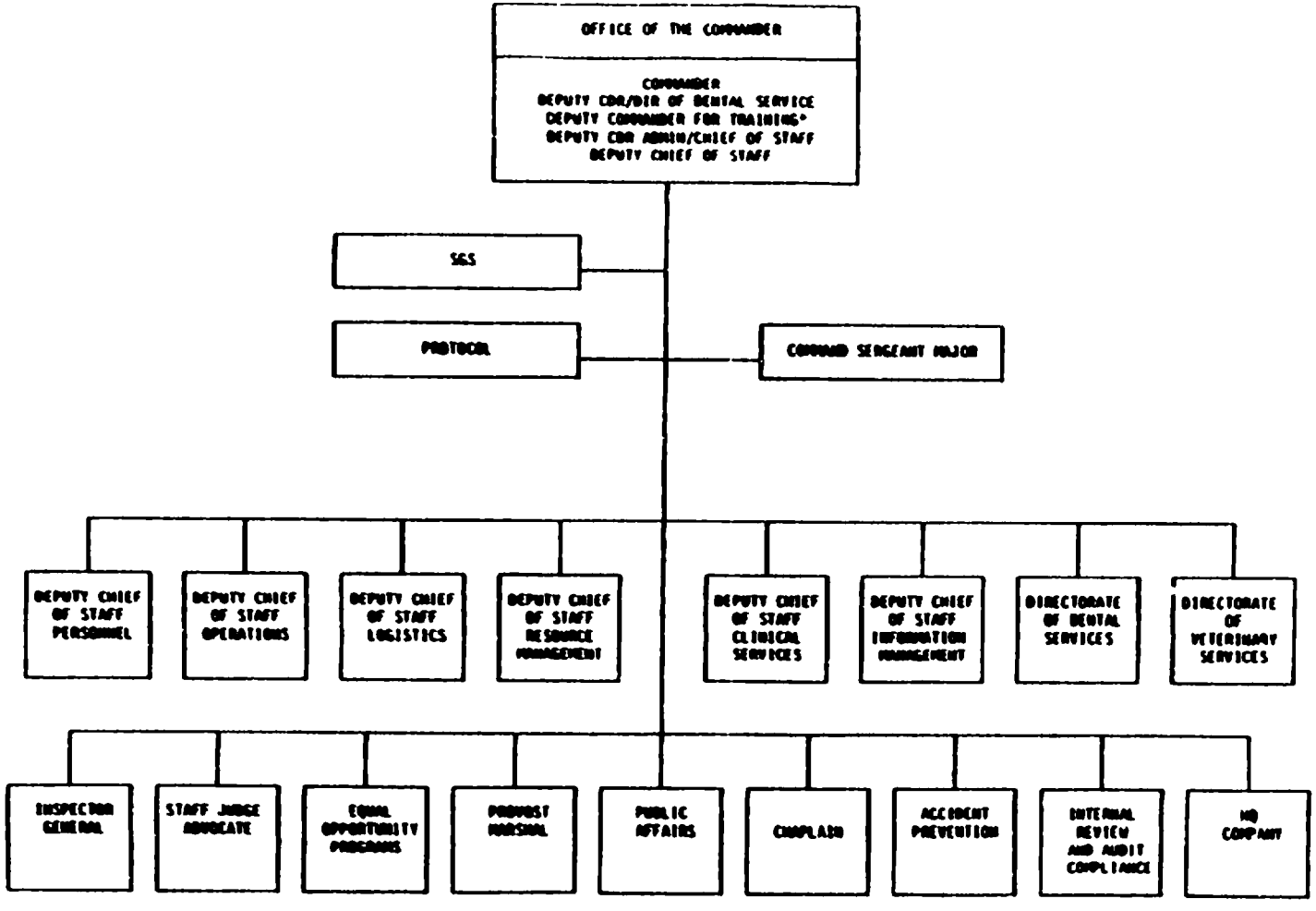
1. DENTACS which are configured for peacetime dental care.

2. Numbered Dental Detachments structured for contingency and wartime operations.

3. Area Dental Laboratories (ADLs) to fabricate dental prostheses.

The dental detachments of the active component are deployed to support U.S. forces in Korea and Europe. DENTACS are likewise stationed in Korea, Europe, and Japan to augment the provision of peacetime dental care. The overseas dental units come under the command of 7th Medical Command (7th MEDCOM) in Europe, 18th MEDCOM in Korea, and U.S. ARMY Japan (USARJ) in Japan. As troop strengths decline overseas, it is anticipated that many of the supporting dental units will be inactivated or converted to the reserve components. The MEDCOMS will grow smaller but the fundamental structure will remain the same. The concern of the Dental Corps is for the potential loss of the one star billet of the Deputy Commanding General, 7th MEDCOM. The Corps needs this or a similar billet as an incentive to retain its brightest and best Colonels. With a decreased potential for promotion into positions of greater responsibility their will be a tendency for the finest DC Officers to retire at 20 years.

Within the continental U.S. (CONUS), Alaska, Hawaii, and Panama all DENTACS and the ADLs are assigned to the Medical MACOM, HSC. One dental detachment is assigned to Forces Command (FORSCOM) for support of contingency missions. The Commanding General (CG) of HSC executes direction and authority over the assigned dental units. The conduit for the CG's command is the Directorate of Dental Services (DDS) within Headquarters, HSC (fig. 1). The DDS exercises operational oversight of the DENTACS



* Commandant, AMS serves as the Deputy Commander for Training

Figure 2-2. Headquarters Structure

Source: HSC Memo 10-2, 15 June 1989.

Figure 1

HSC Memo 10-2

and ADLs. The Deputy Commanding General of HSC is a DC officer of one star rank. He is in position to assure that the support rendered by the staff elements of HSC is equitable for dental and medical units alike. The DCG is in the rating scheme of the senior leadership of dental units and staff officers of HSC. One special aspect of the DENTAC is that the collocated MEDDAC or Medical Center (MEDCEN) is responsible for administrative support to the DENTAC or ADL.‹21› DENTACS and ADLs are austere in structure by design. At many installations the dental unit commander serves as the intermediate rater of the staff officers of the MEDDAC or MEDCEN. Where this relationship is established support is facilitated. A key ingredient of the success of the DENTAC is the relationship of the DENTAC Commander to the installation commander, his rater. The DENTAC commander is the Director of Dental Services and a staff officer to the installation commander. The top dentist's "report card" is signed by the leader of the community he serves. The Dental Corps perceives this as the ideal relationship. The senior rating is rendered at HSC either by the CG or DCG depending on the grade of the rater, whom the senior rater must outrank. This system seems to foster efficient operations.

The features discussed above define the DENTAC concept:

1. Dental units commanded by dental officers.
2. A subordinate command coequal to the MEDDAC.
3. Austere in structure.
4. Administrative and logistical support from collocated

MEDCEN or MEDDAC.

5. Responsive to the installation commander.

To understand the DENTAC concept and the relationship between HSC and its subordinate elements is important but in no way does it define the entire spectrum of relationships which impact on dental units. There is another layer of authority, policy oversight, exercised by OTSG. The individual charged with this responsibility is the Chief of the Army Dental Corps in keeping with the provisions of Title 10, Section 3081.

Military medicine and dentistry function within a milieu of regulations, policies, and guidance promulgated not only by DOD, and DA but also by a host of governmental agencies and private accrediting bodies. The American Dental Association (ADA), the American Association of Dental Schools (AADS), the Environmental Protection Agency (EPA), the Centers for Disease Control (CDC), and Practitioner's Databank are just a few of the dozens which impact directly on military dentistry. The Chief must ensure that policies and regulations drafted within OTSG are in consonance with the applicable guidance of these organizations.

The relationship with these external organizations is not a one way street. The Chief takes a proactive approach in dealing with the them during their policy formulation so that when guidance is published it is something the ADCS can live with. In recent years the dental chiefs of all the military departments have provided a unified voice in this effort. The Chief's relationship with these extramural agencies is a major reason why

he needs the two star rank. From a protocol perspective, his rank provides him the status to deal from a position of power and respect. The impact of his stars on his civilian colleagues is not insignificant.

Title 10 requires that the chief will "establish professional standards and policies for dental practice."(22) Dental practice is an operational function and on a daily basis is monitored under the auspices of HSC, but where policy and standards are concerned it is the Chief's responsibility by law. The Corps has established two separate technical channels external to, but cooperating with, HSC to ensure that the Chief receives information on problems or requirements which could result in his decision to alter standards or policies.

The first of these channels is the consultant channel composed of senior officers who are recognized experts in their dental specialties. Each of these consultants keeps abreast of developments within his specialty area in organized dentistry and practices his profession daily. These officers provide sage counsel on advances in clinical practice, research, and education. They can compare how things are, to how they should be. Their input is essential. It helps the Chief make informed decisions. The Senior Dental Corps Staff Officer, who works in the office of the Chief, coordinates the efforts of the consultants.

The second technical channel is the education channel. Advanced dental education is big business in the Army. The ADCS

trains dentists in eight different specialty areas of dentistry. Currently all officers in the grade of colonel have received such advanced training. It is a source of great pride that one-half of the trained officers have achieved the prestigious "diplomat" status of their respective specialty certification boards.(23)

"Education is the bed rock, the backbone, and foundation of the Army Dental Care System" according to MG Lefler.(24) Education is the source of continued improvements in quality of care. Likewise, education fosters readiness by the inclusion of wartime roles training as an integral part of the curriculum of all programs. Furthermore, specialty training is the primary retention tool. As military dentists fall further behind their civilian colleagues in terms of financial remuneration, it may become the only retention tool.

It is in the training programs that DC officers attain proficiency commensurate with the standards established by the Chief. Therefore, in accordance with his duties under Title 10, the Chief closely monitors the education programs to ensure that the standards are taught and met. To assist him in this function he relies on the Chief, Graduate Dental Education Branch (GDEB). The GDEB is a subelement of the United States Army Health Professions Support Agency (USAHPSA), a field operating agency (FOA) of OTSG. Fortunately the GDEB is located in the Surgeon General's office complex because the Chief of the Army Dental Corps and the Chief, GDEB confer daily.

The Chief, GDEB coordinates the activities of the teaching

chiefs and program mentors. Since all of the programs are conducted within HSC DENTACS, he must establish a cooperative relationship with HSC. The Chief, GDEB ensures that all programs meet the accreditation standards of the ADA, for to lose accreditation would be to lose the retention benefits of the programs. Therefore he is the expert on these standards. Furtnermore the Chief, GDEB represents the Corps Chief before the AADS which indirectly sets practice standards by its input to the dental school curriculum.

Another staff officer requires mention. He is The Dental Consultant. This officer coordinates for the Chief those policy actions that cut across all the subspecialities of dentistry e.g. facilities construction, infection control, dental fitness standards etc. He is assigned to USAHPSA but works within the office of the Chief so that he can receive guidance and provide advice on a daily basis.

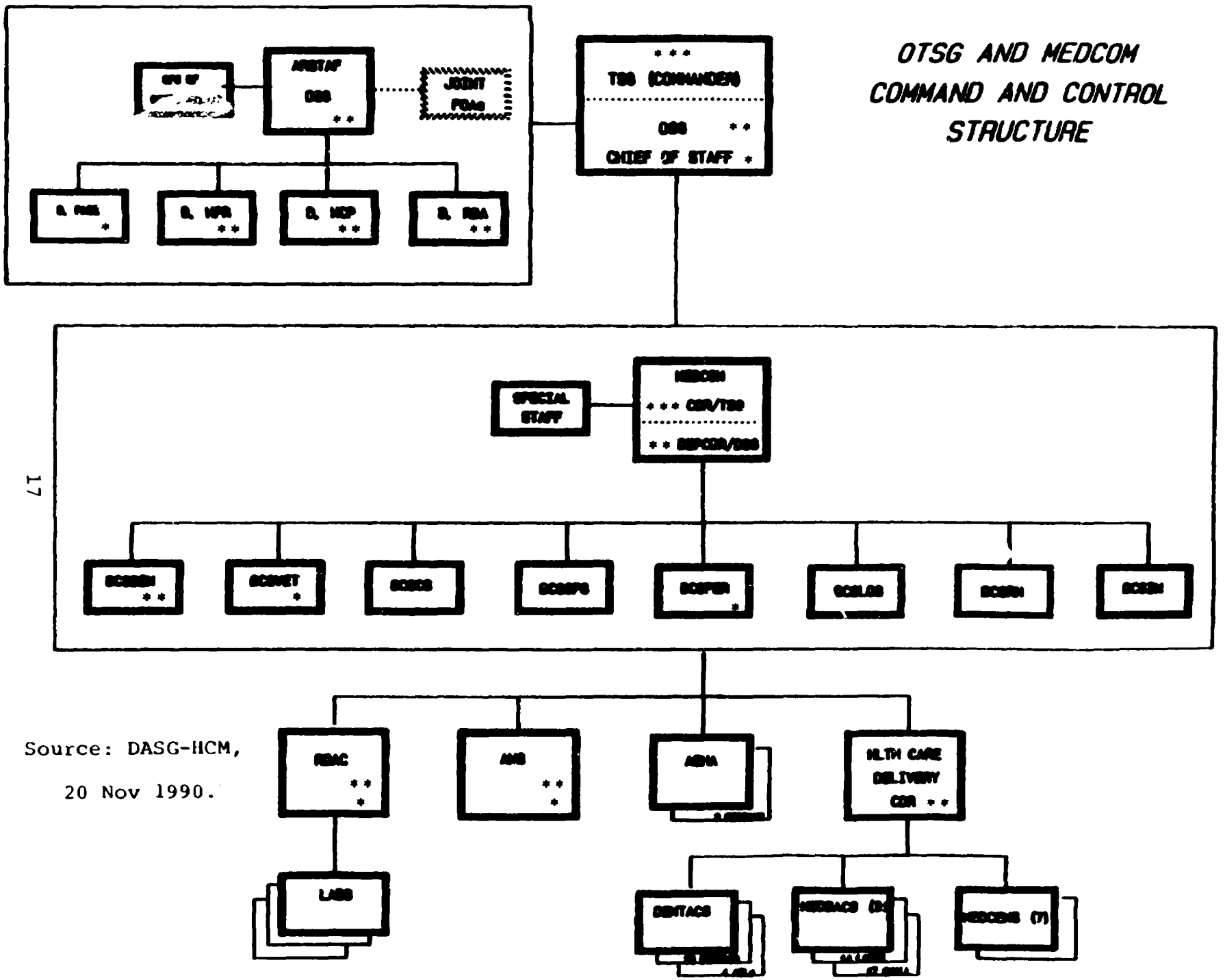
When one views the ADCS from an historical perspective, comparing the "dark ages" with the "golden age" of today, it is clear that certain aspects of the contemporary C2 have been beneficial and merit retention in any reorganization scheme. Premier among these attributes at the installation level is the DENTAC concept. Paramount at the policy level is the position of the Chief on the ARSTAF as the ultimate proponent for all matters pertaining to dentistry. The consultant and education technical channels have worked well to assist the Chief in the exercise of his legal responsibilities and should be kept. Likewise, the

position of The Dental Consultant should be "legitimized" with assignment to OTSG. An operations component such as the DDS will be necessary for oversight of the daily activities of dental units. Placement of DC officers in the rating chains of supporting staff officers has facilitated support relationships and warrants inclusion in any reorganization.

Proposed Reorganization

The proposed reorganization of the AMEDD is designed to correct the deficiencies first identified in the 1986 Command and Control Study and then revalidated in the Command and Control Study 1990 Review. The proposal would collocate the Headquarters of the Medical MACOM with OTSG in the NCR. The new structure (Fig. 2) would be composed of a policy making ARSTAF element and a medical MACOM responsible for command, management and operations.(25)

Major milestones in the implementation of the reorganization have been identified.(26) TSG will assume command of the medical MACOM not later than (NLT) 1 October 1993. The Field Operating Agencies (FOAs) will be eliminated by 30 September 1993. A transitional major subordinate command (MSC) of the medical MACOM called Health Care Delivery Command (HCDC) will be established NLT 1 October 1993 as an interim measure. A second MSC, the Research, Development, and Acquisition Command will be established NLT 30 September 1993. Physical collocation in the NCR will occur NLT 30 September 1995 with contemporaneous



Source: DASG-HCM,

20 Nov 1990.

Figure 2

deactivation of HCDC.

The AMEDD ARSTAF is outlined in Fig. 2. It is composed of TSG, DSG, the Chief of Staff, and the Assistant Surgeons General for Dental Services and for Veterinary Services. There will be a small element for the special staff and austere staffing for the offices of the Corps Chiefs. Major subordinate officers of the ARSTAF will include the Directors of Program Analysis and Evaluation (PA&E), Health Preparedness and Readiness (HPR), Health Care Policy (HCP), and Research Development and Acquisition (RDA). They will be under the direction of DSG. Current OTSG FOAs will be realigned under functional components of the new MACOM. Joint FOAs will continue to exist and coordination will be effected through the AMEDD ARSTAF.

The new MEDCOM is likewise shown in Fig. 2. Three existing organizations will be realigned as major subordinate commands of the MEDCOM:

1. U.S. Army Environmental Hygiene Agency (USAEHA).
2. Academy of Health Sciences (AHS).
3. Research and Development Command to be retitled as Research, Development, and Acquisition Command (RDAC).

The existing subordinate commands of HSC will flesh out the execution end of the MEDCOM:

1. 36 DENTACS and 4 ADLs.
2. 31 MEDDACS.
3. 7 MEDCENS.

The staff elements of the MEDCOM will be comprised of the Deputy

Commander, Commander's Special Staff, and the 8 Deputy Chiefs of Staff for Dental Services (DCSDEN), Veterinary Services (DCSVET), Resource Management (DCSRM), Clinical Services (DCSCS), Operations (DCSOPS), Personnel (DCSPER), Logistics (DCSLOG), and Information Management (DCSIM).

Staffing of the ARSTAF and MEDCOM will be austere by today's standards. Senior officers will be dual and triple hatted. It is proposed that ASG for Dental Services/Chief of the Dental Corps also be the DCSDEN of the MEDCOM.

The ADCS is proud to support the major tenets of the proposed reorganization in that they should reduce layering and the inefficiencies that layering has at times produced.‹27› Furthermore, with an organization as lean as the ACDS it is advantageous to reduce the number of offices and agencies with which it must coordinate. However, it would be a serious error to accept the new structure in its entirety. It is too austere to support both the ARSTAF functions of the ASG for Dental Services and the operations of the 36 DENTACS and 4 ADL's.

Within the new structure the support staff dedicated to the ADCS is not sufficient to accomplish its responsibilities. The proposed staffing is as follows:‹28›

1. ARSTAF
    a. The ASG for Dental Services.
    b. The Dental Consultant.
    c. Secretary
2. MEDCOM

a. DCSDEN (dual hatted as ASG for Dental Services).

b. Senior Dental Corps Staff Officer.

c. Director of Dental Services.

d. Chief of Clinical Services.

e. Dental Care Administrator.

f. Management and Studies Officer.

g. Staff Dental Non-commissioned Officer.

h. Clerk Typist.

3. Other

a. Chief, GDEB under the MEDCOM DCSPER.

b. Assistant Inspector General, MEDCOM special staff.

This staffing is a dramatic reduction from the current structure without decrement in mission. Presently, there are 6 officers, 2 secretaries, and 1 non-commissioned officer working in the office of the Chief. The reorganization will reduce this staff by 6. Within HSC there are 6 officers, 2 non-commissioned officers, 2 secretaries, and 1 civilian management analyst supporting the dental units. Reorganization will reduce the MEDCOM staff by 3. Overall reduction will be 9 personnel. A decrease in strength of this magnitude will be disastrous to mission accomplishment unless every efficiency gained during the "golden ages" is retained.

It is reassuring that the DENTACS appear to survive intact and that the Chief's position within the ARSTAF is maintained. Assignment of The Dental Consultant to the ARSTAF is lauded. It recognizes formally a relationship that already exists and has

been extremely beneficial for the ADCS and the AMEDD. The placement of a DC Brigadier General as Deputy Commandant of AHS is a tremendous improvement. It is consistent with the amount of dental training that occurs at the Academy and reflects the importance of dentistry in the overall provision of health services.(29) It will have a most salubrious effect on the morale of the students and faculty of the Academy's Dental Science Division and the ADCS. The retention of the technical channels through the positions of The Senior Dental Corps Staff Officer and Chief, GDEB is likewise a very positive aspect of the proposed reorganization. The basis of an effective organization is there. What is required to make the reorganization work most efficiently for the ADCS is a number of subtle modifications.

Recommended Modifications to the Reorganization

The first and most important modification is that the Chief, Army Dental Corps should be the Deputy Commanding General for Dental Services within the MEDCOM. He should not be the DCSDEN. This parallels the current structure within HSC where a DC Brigadier is the DCG. This modification will present two decided advantages for the ADCS. First, it places the Chief above the MEDCOM staff. From this position he can monitor the support provided to the subordinate dental units. He will be in the rating chain of the staff and in position to ensure that efficient support relationships are established. This is the system that has worked so well for HSC and has been such a boon

for the DENTAC concept. The second advantage is that it fulfills the intent of Congress as expressed in Title 10: "all dental functions of the Army shall be under the direction of the Chief of the Dental Corps."(30) It is only at the pinnacle of the AMEDD where control of the Dental Corps resides in a physician and that physician is The Surgeon General.

The second modification is that the DCSDEN should be a DC Brigadier. The DCSDEN will provide oversight for the management and operation of the 40 dental units within the MEDCOM for the Chief. He will be the senior rater for the subordinate dental commanders except in such cases where the installation rater is senior to the DCSDEN and the report is kicked "upstairs" to the DSG for Dental Services. This relationship will allow the Chief to focus on his ARSTAF responsibilities--providing advice to HQDA as the Chief of the Army Dental Corps and policy guidance to the ADCS as the ASG for Dental Services--while still exercising his prerogative to direct all dental functions. This change requires only a single addition to the staff. The General Officer billet could easily be removed from 7th MEDCOM as forces deployed to Europe reduce in strength. Furthermore, this brings the DCSDEN closer in line with the other Deputy Chiefs of Staff from a rank perspective--none will be senior to a Brigadier.

This second modification will not only allow the most efficacious execution of the Chief's statutory responsibilities but it will also have a very positive effect on morale. In the wake of the force drawdown it will maintain a highly visible and

important role for a DC brigadier as DCSDEN. The one star billet might otherwise be lost, creating a chilling effect upon the morale of the ADCS.

The third change is the addition of a Medical Service Corps Administrative Officer to the Office of the Chief, Army Dental Corps. This individual will fulfill those responsibilities for the ADCS external to the MACOM that the Dental Administrator and Dental Management and Studies Officer discharge within the MACOM. He will monitor, collect, and manage dental workload data from non-MACOM dental units and be the mentor of the units' Executive Officers and Field Medical Assistants.‹31›

Even the physical layout of the new structure is important. A fourth recommendation is that the office of the Chief be contiguous to the HPR division within the ARSTAF. COL Donald C. Hobaugh, Dean of the Medical Field Services School, believes that the ADCS has had little impact on health care operations planning.‹32› Staffing of the ADCS has been too constrained to assign an officer dedicated to field dental operations planning. In such a situation the ADCS has been somewhat "out of sight and out of mind". In the new structure staffing will likewise be constrained, but with contiguous offices, mere physical proximity will make it easier for the ADCS to monitor operations planning without an additional manpower requirement.

The fifth modification is simple and just plain common sense. Both the offices of the Chief and the MEDCOM staff require more clerical support. An additional secretary should be assigned to

each office to prepare and file correspondence, answer telephones and perform other clerical duties. It would certainly be foolish to burden the small professional staff with tasks that the clerical staff should perform.

Summary

The review of the history of the ADCS demonstrates that there is good reason to be concerned with any proposed reorganization of the AMEDD. An efficient system for the delivery of dental care was destroyed once before through restructuring. The Dental Corps supports the concept of reorganization but wishes to maintain those aspects of the current system which have fostered the present "golden age" of Army dentistry. Aspects which must be retained are the DENTAC concept, the Chief's place on the ARSTAF, the technical channels, an operational element within the MEDCOM staff, and a place within the rating scheme of the supporting AMEDD staff.

The proposed reorganization protects these features in structure but, unfortunately, may jeopardize them in function. I recommend that the Chief of the Army Dental Corps be slotted as the DCG for Dental Services rather than the DCSDEN and that the DCSDEN be a Brigadier General DC Officer who manages the dental units within the MEDCOM for the Chief. This minor modification will allow the Chief to focus on his ARSTAF responsibilities in accordance with Title 10 and at the same time ensure that the operations of the MEDCOM's dental units are directed effectively

for him by a senior DC Officer. I recommend that a Medical Services Corps Officer be added to the office of the Chief, and that the Chief's office be contiguous with HPR Division to have greater impact on operations planning. The addition of clerical personnel will likewise foster efficiency. The cost of these recommendations in terms of additional manpower requirements is insignificant compared to the achievements of the ADCS which the modifications will protect.

ENDNOTES

1. LTG Quinn H. Becker, Office of the Surgeon General, Memorandum to the Chief of Staff of the Army, 28 September 1987.

2. U.S. Army Medical Department, Command and Control Study 1990 Review, p. 9.

3. MG Alcide LaNoue, AMEDD in Transition, A Road Map for Change, p. 45. Cited with special permission of MG LaNoue.

4. Ibid., pp. 2-3.

5. George F. Jeffcott, A History of the U.S. Army Dental Service in World War II, pp. 1-3.

6. U.S. Army Health Services Command, Historical Highlights of the Army Dental Corps, p. 4.

7. Jeffcott, pp. 15-21.

8. Ibid., p. 9.

9. Thomas G. Reddy, Jr., COL, The Army Dental Care System: 1975-1989, p. 2.

10. U.S. Army Health Services Command, p. 7.

11. U.S. Army Military History Institute, Senior Officer Oral History Program, Project 1990-2, Major General Bill B. Lefler, USA, p. 65.

12. Reddy, pp. 2-3.

13. Reddy, pp. 4-6.

14. U.S. Laws, Statutes, etc. United States Code, 1988, Vol. 3, Title 10, sec. 3081, p. 764. (hereafter referred to as "U.S.C.")

15. U.S. Army Military History Institute, pp. 18-19.

16. Reedy, pp. 12-13.

17. Association of the United States Army, Special Report: Caring for the Troops in Peace and War, p. 26.

18. MG Bill B. Lefler, Address to the Dental Commanders Conference, 3 May 1990. Cited with special permission of MG Lefler.

19. Interview with Bill B. Lefler, MG, Office of the Chief, Army Dental Corps, Washington, 9 November 1990.

20. Association of the United States Army, p. 27.

21. U.S. Department of the Army, Army Regulation 40-1, p. 2-2.

22. U.S.C., p. 764.

23. Interview with Gary E. Allen, COL, U.S. Army Health Professions Support Agency, Washington, 9 November 1990.

24. MG Bill B. Lefler, Address to the Teaching Chief's Conference, 23 January 1990. Cited with special permission of MG Lefler.

25. LaNoue, p. 47.

26. Ibid., p. 51.

27. Interview with Douglas A. Lake, LTC, Office of the Chief, Army Dental Corps, Washington, 9 Nov 1990.

28. Ibid.

29. Interview with William P. Cruse, COL, Academy of Health Sciences, San Antonio, 3 December 1990.

30. U.S.C., p. 764.

31. Interview with Stephen L. Markelz, LTC, U.S Army

Health Services Command, San Antonio, 3 December 1990.

32. Interview with Donald C. Hobaugh, COL, Academy of Health Sciences, San Antonio, 4 December 1990.

BIBLIOGRAPHY

Allen, Gary E., COL. U.S. Army Health Professions Support Agency. Personal Interview. Washington: 9 November 1990.

Association of the United States Army. Special Report: Caring for the Troops in War and Peace. Washington: December 1989.

Becker, Quinn H., LTG. Office of the Army Surgeon General. Memorandum to the Chief of Staff of the Army, 28 September 1987.

Cruse, William P., COL. Academy of Health Sciences. Personal Interview. San Antonio: 3 December 1990.

Hobaugh, Donald C., Col. Academy of Health Sciences. Personal Interview. San Antonio: 4 December 1990.

Jeffcott, George F. A History of the United States Dental Service in World War II. Washington: U.S. Government Printing Office, 1955.

Lake, Douglas A., LTC. Office of Chief, Army Dental Corps. Personal Interview. Washington: 9 November 1990.

Lefler, Bill B., MG. Address to the Dental Commanders Conference. West Point: U.S. Military Academy, 3 May 1990. (Cited with special permission of MG Lefler.)

Lefler, Bill B., MG. Address to the Teaching Chiefs Conference. San Antonio: 23 January 1990. (Cited with special permission of MG Lefler.)

Lefler, Bill B., MG. Office of Chief, Army Dental Corps. Personal Interview. Washington: 9 November 1990.

Markelz, Stephen L., LTC. U.S. Health Services Command. Personal Interview. San Antonio: 3 December 1990.

Reddy, Thomas G. Jr., COL. The Army Dental Care System: 1975-1989. Thesis. Carlisle Barracks: U. S. Army War College, 5 February 1990.

U.S. Army Health Services Command. Historical Highlights of the Army Dental Corps. San Antonio: U.S. Army Health Services Command, 1974.

U.S. Army Medical Department. Command and Control Study 1990 Review. Washington: Office of the Army Surgeon General, 1990.

U.S. Army Military History Institute. Senior Officer Oral History Program, Project 1990-2, MG Bill B. Lefler. Carlisle Barracks: 20 December 1989.

U.S. Department of the Army. Army Regulation 40-1: Composition, Mission, and Functions of the Army Medical Department. Washington: 1 July 1983.

U.S. Laws, Statutes, etc. United States Code. 1988 Ed. Washington: Government Printing Office, 1989. Vol. 3, Title 10, sec. 3081.